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Federal, State Veterans Treatment Groups Cooperate For Care of Returning War Veterans and Families

In the past year there has been a unique confluence of professional provider concern and energy sufficient to stir large organizations to action. The aim of these stirrings has been to create effective outreach and treatment for what is expected to be large numbers of individuals with war-related trauma problems. Interestingly, these efforts have happened without anyone directing or insisting upon interagency collaboration., the issuance of directives, the organization of regional meetings, or threats of congressional scrutiny. Rather, attentive and able clinicians have observed the nature of the current war and have accurately discerned that there will likely be a significant need for services, especially behavioral and mental health treatment in the months and years to come.

The story of this interagency effort could easily be lost with the passage of time and the influence of institutional dynamics. As a result, the *RAQ* staff has decided to attempt to tell this story and to name as many people as known to us who have been involved in this effort. In particular, those who are believed to have contributed to the war-trauma treatment collaboration effort. The risk of naming people includes the potential of failing to report the names of those who have been very important to the process yet unseen. So, the staff of the *RAQ* encourages readers to tell us of any historical gaps and omissions.

The Genesis

In the fall-winter of 2003 it was already very apparent that Operation Enduring Freedom (OEF-the war in Afghanistan), and Operation Iraqi Freedom (OIF) were going to be significant sources of combat exposure and traumatic stress. Most people I know were aware of this before the war was declared "mission completed." An early discussion with some colleagues in the fall of 2003 had found a hopeful belief that both wars would soon end. It was not long after that discussion, that most treatment providers became anxious with their own optimism, as daily reports of close quarters combat continue to be heard.

In January, 2004 I had a discussion with Steve Hunt, MD, Puget Sound Health Care System, about the returnee issue. He was already setting up the Redeployment Clinic at the Seattle VAMC for returning and discharged veterans. He was putting together a booklet with comprehensive information for redeployed military to review and use as personal needs were identified. Leigh Hayes, MSW and Michele Klevens, MS were listed as screeners and providers for veterans. Characteristic of Dr. Hunt's inclusive nature, he asked that I provide information about WDVA programs and services for the booklet. An updated edition is reportedly in the works.

A few days later, I met with Rob Ramsey, MSW, Team Leader of the Tacoma Vet Center. Rob had wisely organized a gathering of VA providers who work in critical roles at Madigan Army Hospital (Brooke Eggimann, MSW, and Linda Gillespie-Gateley, MSW), and Gene Finney, VARO Service Officer who performs redeployment briefings. These individuals reported on their work with wounded and rotating military members, as well as National Guard members, offering post-deployment screening, treatment referral, or in Gene Finney's case, VA benefits information. The reality of the wars became clear as Brooke and Linda talked about wounded soldiers and the nature of the wounds being treated at Madigan Army Hospital. Gene added an additional painful dose of reality as he described being part of the "notification" process, wherein family members are told of the death of a loved one. This meeting stirred us deeply as we began to consider what more we could do to assist the veterans and family members.

At about the same time I had brief discussions with Marcus Neimuth, MD, Chief of Emergency Psychiatry, Miles McFall, PhD, PTSD Program Director, Michele Klevens, MS and Murray Raskind, MD, MICICC, Robert Barnes, MD, Chief of the Mental Health Clinic, and Evan Kantor, MD, PhD, all at the Seattle Puget Sound Health Care System. Each of them demonstrated a desire to address the painfully obvious and growing need for services. This desire was best characterized by Miles McFall, "I need to get involved helping these veterans...it is just the right thing to do."

Identifying the Treatment Populations

The Washington State National Guard is made up of state residents who are essentially activated, trained, deployed, and then redeployed (sent home) to become war *veterans*. This is also the case for returning military members who are discharged and come to reside in Washington State. They,

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together, create two population streams of veterans for treatment systems to be concerned about. Among other things, we needed to find ways of connecting with returning soldiers who were soon to be discharged back to civilian life. Others come home, but then are deployed for additional tours to Iraq and elsewhere. Others still, have military specialties that preclude discharge altogether (Stop-Loss Program), exposing them to indeterminate tour length.

Unanticipated Connections

The search for connections to returnees led to two very unique outcomes that continue to amaze me. The first was an effort that started with conversations with John Lee, Deputy Director of WDVA, about accessibility to the National Guard Family Support Network, and concerns about how to create informational links to families and returnees. Connections with the National Guard that had been developed 12 years ago secondary to *Operation Desert Storm*, had more or less evaporated due to personnel changes and the passage of time. We needed to re-energize our connections within the National Guard, Ft. Lewis, and all other deployed military and reserve units. John immediately organized a meeting with the National Guard Commander, Col. John Touley. This quickly led to discussions with Lt. Col. Beverly White and Lt. Col. Mary Forbes at Camp Murray. The eventual meetings brought together service organizations, VA Medical Center mental health and PTSD programs, the Tacoma Vet Center, the American Red Cross, and the WDVA PTSD Program. Rather quickly it was understood that we needed to formalize our linkage, agree to offer specific direct services and support to returning members of the Washington State National Guard and reserve units. This agreement will be formalized later this fall and will likely be extended to all military reserve units in the state.

The other major and unanticipated linkage resulting from this effort to connect veteran services with returning military, has been among the most astonishing. While it has been known for some time that the VA Medical Centers of the Puget Sound Health Care System have in-place formal working relationships with Madigan Army Hospital, it was not until now that many VA and Madigan staff could easily see how they could fit into that set of agreements. The needs of returning soldiers who become veterans, offered the chance to build on the work of others, and the VAMC-Madigan liaison work of Brooke Eggimann and Linda Gillespie–Gateley. Steve Kubisweski, MA, former Special Forces officer and member of the Behavioral Health Staff at Madigan, extended an invitation to Miles McFall and myself to offer case consultation and program linkage information. This connection, with a further assistances from Jolee Darnell, MS, John Miller, MD, and Russ Hicks, MD, has quickly grown, and now VA PTSD and WDVA PTSD program staff members are able to attend case-centered staff meetings two times per month to offer professional consideration and other assistance to staff and redeployed soldiers. This opportunity to work directly with the active duty military has reminded me of the differences between the missions of military behavioral health, and the role of VA or WDVA mental health programs. Nevertheless, the presence of alternative perspectives in these case meetings appears to offer something beneficial to the overall outcome of specific cases. For returnees/discharged veterans, it has also meant immediate linkage to treatment options. Very frankly, I would have never believed someone, if they had told me just two years ago that I would have this opportunity to assist in this manner. Such events demonstrate again the need for an open mind in all matters of caring for our returning troops, and the creation of methods to connect them to the care they require. Furthermore, the task of developing treatment services requires cooperation among the various treatment resources.

Objective Assessment from the Outside

It is not common that one can hold an opinion about something and then find objective information from far outside of ones own realm of consideration to support that opinion. Nevertheless, a number of weeks ago I had a chance to offer testimony at a congressional hearing initiated by Representative Lane Evans, US Congressman from Illinois. The General Accounting Office (GAO) conducted a itinerant hearing at two VA Medical Center sites in the state. The GAO hearing staffers had been traveling all over the country interviewing VA and DOD personnel to determine the level of interagency work on behalf of National Guard members and veterans coming home from the current wars. At the end of this lively session, the hearings officer volunteered that she had never before seen such intimate connectivity among the various organizations from federal, state, and county government. The closest example she had of such cooperation was in Vermont, but, she admitted, "...the effort here is much more comprehensive."

Postscript

At a VA sponsored conference in Portland last week, I met with various VA staff members within Washington state. These informal hallway chats were an opportunity to assess the depth of the statewide mental health efforts on behalf of OIF and OEF returnees. I was very encouraged that these providers had clearly considered critical issues, and are preparing for the elevated service demands. Some express concern about sufficient funding/staffing levels, and others noted the upcoming VISN 20 "PTSD Summit" as a method of connecting-the-dots toward seamless services.

Because WDVA receives a DD 214 for each discharged veteran with a Washington state address, we are already sending returning guard members and veterans periodic letters during the year following re-deployment. Each message will anticipate needs that may arise for the veteran or family, secondary to deployment and their return home. It is our hope that OIF and OEF veterans will be encouraged to seek help earlier than veterans of other wars, thereby perhaps avoiding some of the consequences of compounded stress and PTSD, family loss, career problems, and even the loss of life.

WDVA PTSD Program contractors are already seeing a number of veterans and family members of OIF/OEF. We will be seeking additional resources to support these activities, and we anticipate significant legislative interest in our intergovernmental efforts. I am not certain there will be sufficient resources to meet the needs of our returnees. However, M. Gandhi offers us encouragement, if not fatalistic guidance, *"Whatever you do will not be enough, but it matters enormously that you do it." ts ##*

Seattle Newspaper Reports PTSD in Iraqi Veterans

On August 27, 2004, the *Seattle Post Intelligencer* featured a front page story on the traumatizing aspects of the war in Iraq: "The unseen cost of war: American Minds. Soldiers can sustain psychological wounds for a lifetime." *PI* reporter, M.L. Lyke, interviewed several Iraqi War veterans after their return from deployment and interviewed several "Puget Sound PTSD specialists." The author quoted an authoritative medical journal expecting around 17% of the returning veterans will have PTSD.

M. L. Lyke quoted WDVA/King County Veterans Program contracting psychologists Tom Wear and Mike Phillips, as well as doctors Steve Hunt and Evan Kanter of the Seattle Puget Sound Health Care System. The *PI* reporter noted the differences between the Vietnam War era and the current atttitude toward veterans in terms of homecoming welcome. However, the article noted, "The study in the *New England Journal of Medicine* indicates 95 percent of Marines and Army soldiers in Iraq have been shot at, 56.5 percent have killed an enemy combatant and 94.5 percent have seen bodies or human remains."

The author interviewed an Iraqi War veteran highlighting the problem of stigma. Before their return, soldiers were counseled in groups and given informational fliers about PTSD, but, said the veteran, the only soldiers who acknowledged having it were "faking." The article described a scene in which returning soldiers were screened for PTSD and found that saying "yes" to the questions meant being held up in processing out.

The *PI* article cited telephone resource numbers for veterans, noting the VA's open door policy to treating the veterans returning from their deployments, as well as the WDVA PTSD program, and listed 8 lines of symptoms, including guilt. In the concluding paragraph, author M.L. Lyke writes: "All the soldiers in these stories served in Iraq. Most asked that their name not be used, for fear of repercussions. They agreed to talk in hope it would help others serving in uniform. Those diagnosed with PTSD and PTSD symptoms are all in treatment."

Comment

The *PI* article is like many journalistic efforts these days in which reporters present the current news. Interviewing actual veterans with PTSD is usually a key to the story's authenticity, however, the line "They agreed to talk in hope it would help others serving in uniform" highlights the risk of exploiting the veteran's own symptomatic guilt. Telling one's story to help others is also a recruiting rationale for many projects in mental health research. For this reason, counselors and contractors working for the WDVA and King County Veterans decline to expose clients to journalists. While the journalist's goal is to report a story, the therapist's goal is to help the client manage and ameliorate symptoms. While telling one's story may be part of the therapeutic process, the form the telling takes, should come from the client. EE/ts ##

Disaster Rescue Workers Examined for Acute Stress Disorder, PTSD, Depression

Researchers at the Bethesda Uniformed Services University contacted 116 disaster workers who had been exposed to rescue efforts after a DC-10 that crashed and burned. Of the 355 passengers on board, 112 people died, 59 were seriously injured, and 184 survived. Workers were examined within 16 days, 7 months, and 13 months post disaster. In addition, 217 disaster workers from other locations, not involved with the rescue, were used as a comparison group.

Researchers Carol Fullerton, Robert Ursano and Leming Wang published their results in the *American Journal of Psychiatry* [2004, 161(8), 1470-1476]. They found 45 subjects were exposed to physical danger in the rescue efforts, 98 subjects worked with or assisted survivors, and 131 subjects worked with the dead. Fullerton, et. al., found that the exposed disaster workers had significantly higher rates of acute stress disorder than comparison subjects (25.6% compared to 2.4%), "significantly higher rates of PTSD at 13 months (16.4% versus 10.0%)...and depression at 7 months (21.7% versus 12.6%)..." (p. 1371). They noted that "exposed disaster workers who were younger were at greater risk of acute stress disorder," and "unmarried subjects were 2.26 times more likely to develop acute stress disorder than those who were married..." (p. 1371).

The authors also noted that exposed disaster workers with "previous disaster experience were 6.77 times more likely to develop PTSD at 13 months...." (p. 1372). Fullerton, et al., also observed that "of those exposed disaster workers with PTSD, slightly less than 50% also had co-morbid depression" (p. 1372). "Nearly 40.5% of the exposed disaster workers in this 13-month study met criteria for at least one diagnosis (ASD, PTSD, or depression)" (p. 1374).

The authors concluded their report in summary: "Our results indicate that exposed disaster workers with previous disaster experience are 6.77 times more likely to develop PTSD" (p. 1374). They note that their findings "are consistent with other evidence that previous disaster exposure predisposes to the development of acute stress disorder (...) and PTSD (...)" (p. 1374).

Comment

It seems reasonable to assume that disaster workers, with their extensive training, are comparable to U.S. soldiers and marines, and the implications for those troops who are destined for re-deployment back to war zones are that they will be at *higher* risk for depression or PTSD than those first going over, and that those who are younger and single, are the most vulnerable. EE ##

Iraq Returnees and the Stigma of PTSD

A group of doctors at Walter Reed Army Institute of Research, led by Charles Hoge, MD, published the results of their surveys of combattants entering and leaving the combat zones of Iraq and Afghanistan in a recent issue of *The New England Journal of Medicine* ["Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care," 2004, 351(1), 13-22]. Their article was commented upon in an editorial by Matthew Friedman, MD, PhD, "Acknowledging the Psychiatric Cost of War," (pp. 75-77).

Hoge, et al., studied 2,530 soldiers from the 82nd Airborne Division prior to their deployment to Iraq in Jan., 2003. They also examined 1,962 infantrymen from the same divison after their return from Afghanistan, 894 soldiers from the 3rd Infantry Division after their 6-month deployment in Iraq, and 815 Marines, upon their return from a 6-month deployment in Iraq. All the returning soldiers and marines were administered questionnaires 3 to 4 months after their return to the U.S., upon their return to duty after leave. It was noted that the participation was voluntary and the research subjects were given "a short recruitment briefing" before the questionnaires were administered. Hoge, et al., noted that the study outcomes focused on current symptoms, occuring over the past month, of major depression, generalized anxiety, and PTSD.

The authors explained that only 31% of the soldiers deployed to Afghanistan reported having engaged in a firefight, compared to 71-86% of those from Iraq. "Rates of PTSD were significantly higher after combat duty in Iraq than before deployment" (p. 16). "For all groups responding after deployment, there was a strong reported relation between combat experiences,...and the prevalence of PTSD. For example, among soldiers and Marines who had been deployed to Iraq, the prevalence of PTSD (according to the strict definition) increased *in a linear manner* with the number of firefights during deployment: 4.5 percent for no firefights, 9.3 percent for one or two firefights, 12.7 percent for three to five firefights, and 19.3 percent for more than five firefights" (p. 16,italics added).

Hoge, et al., highlighted the problem of delivering treatment to those who report having a mental disorder. "Of those whose responses met the screening criteria for a mental disorder according to the strict case definition, only 38 to 45 percent indicated an interest in receiving help, and only 23 to 40 percent reported having received professional help in the past year (...). Those whose responses met these screening criteria were generally about two times as likely as those whose responses did not to report concern about being stigmatized ..." (p. 16).

Researchers observed a very high level of combat reported from subjects returned from Iraq, with more than 90% "reporting being shot at and a high percentage reporting handling dead bodies, knowing someone who was injured or killed, or killing an enemy combattant..." (p. 17). They also note that reported alcohol misuse was significantly higher among soldiers after deployment than before deployment, "particularly with regard to PTSD."

Adopting what the authors refer to as a conservative research approach, they estimate that "as many as 9 percent of soldiers may be at risk for mental disorders before combat deployment [acknowledging that they were evaluated *just before* deployment] and as many as 11 to 17 percent may be at risk for such disorders three to four months after their return from combat deployment" (p. 20). The authors note that PTSD rate among the general adult population is 3 to 4 percent. They observe sadly that the resistence to seeking help for mental disorders is greatest among those who most need the help, generally because of concern for stigma.

Dr. Friedman's Editorial

Crying "Alas," Matthew Friedman expressed reaction to the Hoge, et al., "report that concern about possible stigmatization was disproportionately greatest among the soldiers and Marines most in need of mental health care. Owing to such concern, those returning from Operation Iraqi Freedom and Operation Enduring Freedom who reported the greatest number or the most severe symptoms were the least likely to seek treatment for fear that it could harm their careers, cause difficulties with their peers and with unit leadership, and become an embarrassment in that they would be seen as weak.

"These findings are consistent with those in an earlier report that showed low use of mental health services among Navy and Marine Corps personnel. In contrast to a rate of 28.5 percent among male civilians with a psychiatric disorder who sought treatment, only 19 percent of servicemen with a psychiatric disorder sought treatment" (pp. 76-77).

Comment

Dr. Friedman and the Hoge and associates research present a challenge to programs designed to provide treatment to returning war veterans. Clinicians who have treated those with PTSD regularly see evidence of stigmatization. Businesspersons and professionals are declined disability insurance if they cite PTSD. Clients regard having PTSD as a handicap to developing intimate relationships, both because of the symptoms of the disorder, and also because of the popular understanding of the nature of the disorder. Spouses of clients with PTSD will attribute emotional expression from the client as pathology, instead of first considering the emotion for its own validity. "Have you taken your medicine?" Clients themselves express their own version of the stereotypes about PTSD by attributing to pathology what might in some circumstances be normal responses. Job applicants lie and conceal their combat exposure, and certainly conceal the diagnosis of PTSD from their prospective employers—for good reason. The stigma exists. The war veteran with PTSD is regarded rather like the proverbial left-handed baseball pitcher who has only marginal control of his location, and even less control of his emotional reactions.

Acceptance of the role of being a war veteran with PTSD is a therapeutic challenge, almost as great as the task of putting the role in its proper place in life. EE ##

Movie Review:

The Human Stain: A Study of Stigma

Reviewed by Emmett Early

I chanced upon *The Human Stain*, not knowing its content, but attracted to the quality of its cast: Anthony Hopkins, Nicole Kidman, and Ed Harris. The regretable title makes one think of laundry. Anthony Hopkins, who seems physically more powerful as he ages, plays Coleman Silk, a classics professor at a local college, Athena. We see him lecturing about Achilles in the *Iliad* and the hero's willingness to abandon duty for a woman, a captured slave, a prize. Coleman, as it happens, is guilty of the same hubris. He has abandoned his African-American birth family to pursue his career and marriage as a Caucasian. The story is conveyed in flashback with Wentworth Miller as young Coleman. In a fateful irony, Professor Coleman is charged with racism, when he refers to two students who have never attended his class as "spooks." Turns out they were African Americans and insulted by the term. Accused of making a racist slur, (although he contended that he had never seen the students and did not know their race), Coleman storms out of the meeting, resigning his professorship. His wife (irony piled on irony) collapses and dies in the emotional wake—the woman for whom he abandoned his African haritage.

Coleman by chance meets Faunia Farley (Nicole Kidman), who is also a piece of work. Faunia describes an incestuous assault from her stepfather, causing her to abandon her wealthy heritage after her mother accuses her of lying. Faunia marries an abusive Vietnam War veteran, Lester Farley (Ed Harris).

Hopkins is convincing as Coleman, a man who was a boxer in his youth, stocky, maybe no longer so tough, but unafraid. He is enough of a man to attract Faunia, who appears to be some 20-30 years his junior. [Old male movie reviewers love these plots.] Ed Harris' role is limited, but as usual, he is convincing and powerful. Faunia describes him as a 2-tour Vietnam veteran who has been hospitalized at the VA. (Adding tours to one's record apparently magnifies the Vietnam influence.) Lester is obsessed with the belief that his ex-wife caused the deaths of their two children.

The Human Stain was directed by Robert Benton, with dark photography by Jean Yves Escoffier, who died after the production and to whom the film was dedicated. The story is from a novel by Philip Roth, adapted in a screenplay by Nicholas Meyer.

Nicole Kidman is mercurial in her ability to transform her appearance. She plays a sensuous working woman with a cobra tatooed on one arm and another at the bottom of her spine. She works as a store clerk and a farm hand. When her ex-husband drives up in his beefy truck to harass her by revving the engine, Coleman wants to confront him with a crowbar, but she cautions him, saying her ex-husband is "out of his f..... mind, he was in Nam, did two tours." When the cops haul him away, Les shouts, "This is payback for what I did in Nam…, for saving my f..... country!"

If there's any doubt about stigma associated with PTSD or combat status, look at how it spreads. Stay away from my ex-, he's a Vietnam vet—did two tours. ##

ISTSS Annual Meeting to be in New Orleans, Nov 14-18

The International Society for Traumatic Stress Studies will hold its 20th Annual Meeting in New Orleans, November 14-18, 2004. The theme, in keeping with current events, is "War As A Universal Trauma." Co-chairs Josef Ruzek, PhD, and Patricia Watson, PhD, describe the meeting plans. "The scope of the 20th annual meeting is broad in recognition of the diverse types of populations affected by war: active duty personnel, veterans, civilian adults and children exposed to war trauma, aid workers, refugees and internally displaced persons. Trauma types experienced by these populations include combat, peacekeeping, terrorism and bioterrorism, as well as torture, sexual trauma and other types of violence that may occur during an armed conflict. Topics will range from basic science and epidemiology to treatment and prevention, as well as policy and other issues of social relevance."

The opening plenary address this year will be given by *New York Times* reporter Chris Hedges, author of *War is a Force That Gives Us Meaning.* Meeting workshops and seminars cover a range of topics emphasizing military psychiatry and the impact on civilian populations, warfare, and terrorism. Again this year there will be so-called "Master Clinician sessions" examining treatment of panic attacks and grief, and outlining the application of "dialectical behavioral therapy." New this year, apparently a step above the masters, are "Expert Clinical Consultations." These consultations feature Robert Pynoos, MD, on developmental psychopathology, Arieh Shalev, MD, on hospital emergency room terrorism response, and Richard Bryant, Ph.D. on cognitive-behavioral treatment for acute stress disorders. Also added this year, in addition to pre-meeting institutes, are post-meeting institutes, all of which will give one what amounts to a lifetime supply of continuing education credits.

And on the streets between these heavy meetings there will be Creole cooking and genuine Cajun music for professional self-care. EE ##

RAQ Retort

The *Journal of Traumatic Stress* doesn't invite comment, but we do. If you find that you have something to add to our articles, either as retort or elaboration, you are invited to communicate via letter or Email. And if you have a workshop or a book experience to tout, rave, or warn us about, the *RAQ* may play a role. Your contributions will make a difference. Email or write to WDVA.

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Bellingham Contractor Visits 173rd Airborne In Italy After Their Return from Iraq

By Bridget Cantrell

Over the course of a year, my relationship with the 173rd Airborne Brigade was formed through an ongoing e-mail exchange with the chaplains on the ground in Iraq. These paratroopers of the 173rd made the night combat jump in early 2003 to open up and secure the northern front in Iraq.

The initial contact with the personnel of this Brigade was made through Chuck Dean, Vietnam War veteran and author of several books on PTSD and spirituality, while serving as the National Chaplain (Emeritus) for the 173rd Society. In mid 2003, I began communicating with key people of the 173rd Airborne, and soon thereafter I contacted Chuck Dean and collaborated with him on writing and designing a new course workbook. The focus of this book, *Turning Your Heart Toward Home*, is to help those returning from the war reintegrate and rebuild relationships with loved ones at home. As a result of working together on this project, an invitation was extended to us to provide information about the ramifications of the impact of war on the returning combat troops from Iraq. My years of experience in counseling and working with veterans and families through the WDVA PTSD Program was invaluable in bringing simple understanding about combat stress to these troops who had just returned from combat in northern Iraq.

We arrived in Vicenza, Italy, on May 24, 2004, and were escorted to Camp Ederle, the home of the 173rd, by Army chaplains Major Tom Wheatley and Captain Steve Cantrell (no relation to me). These wonderful men did an excellent job in arranging all our meetings and services. As well as our logistical needs, they helped set up battalion-sized meetings plus individual and small group counseling sessions with the troops.

The next day we had the opportunity to address the issues of posttraumatic stress disorder with over 2,500 men and women from three battalions and one artillery battery of paratroopers. Each session began with Chuck relating his own experiences, his stressors of war, and his challenges of returning home from war in 1966.

When the program was then turned over to me, I presented a power point introduction to describe the basic aspects of PTSD and readjustment issues. The presentation was given in a way to offer psychological tools to enhance coping skills and illuminate some of the challenges they may encounter along the way.

To help these soldiers gain an understanding of what to expect from witnessing and participating in combat, it was critical to "normalize" their symptoms and reactions. This was accomplished by stressing ideas that what they are feeling, and perhaps acting out, is not out of the ordinary. However, I explained that this is common in those who experience such stressful and traumatic events as found in combat. Our purpose on this mission was NOT to alarm the troops, who were so fresh out of combat, but to help them understand some of the reactions to stress and the "signs along the trail" that they may be experiencing—and many were. It was important to give them a simple understanding of PTSD and to "normalize" their responses to life after war. If done properly, there is a greater possibility that they may be able to recognize and avoid some future problems that could otherwise cause prolonged, unpredictable, and adverse effects.

Our days were spent by presenting information to large groups, small focus groups, and individuals. We believe that many of these troops came away with more effective tools to help them with present and future readjustment issues. As time goes by, we continue to communicate (via e-mail and USPS mail) with some of the troops whom we were so privileged to meet while there. It is our hope that this is just the first of many open doors for us to continue to work in unison with the US military in caring for the troops and their families. ##

Observations made during individual and group discussions:

**There was confusion as to why they had short tempers at this time.*

**Many soldiers were unable to explain their feelings of anger.*

**Some admitted to problems about not getting enough sleep because they had developed routines and habits in the war zone that now dictate their behavior.*

**Many had an uneasiness about their emotional and behavioral responses to their war experiences. They were uncertain as to whether or not these responses will create problems for them in the future.*

**Most of them had little or no tolerance for:*

—Common mistakes or "stupid" behaviors from those around them.

—Prolonged closeness with their loved ones.

—Detailed conversations about the time spent in the war zone.

—Activities that have little or no structure, lack of organization.

Bridget Cantrell, PhD, is a WDVA Contractor and therapist in private practice in Bellingham.

Mustard Gas Testing During WWII Leads to Long Term PTSD and Health Problems

Noting that exposure to toxic chemicals such as mustard gas qualifies as a Criterion A for PTSD in DSM-IV, researchers at Dartmouth Medical School sampled veterans from a national registry of those who participated in the testing of protective equipment against exposure to mustard gas and lewisite. Publishing their results in the *Journal of Traumatic Stress* [2004, 17(4), 303-310], M. Kay Jankowski and associates examined a number of variables using a "Mediational Model" to analyze their results of a sampling of 363 veterans who were exposed to the secret experiments. The authors noted that "Exposure to these compounds has been found to cause long-term physical health problems including chronic bronchitis, conjunctivitis, skin ulceration, and even some forms of cancer. The tests required men to either remain in a chamber with the gas or enter a field that had been contaminated with the gas" (p. 303). These tests remained secret until 1991. The article refers to one of the co-authors, Paula Schnurr, who had previously estimated in 2000 that of those veterans surviving, 32% had PTSD. It was also noted that some of the veterans, who were army and navy personnel, went on to participate in combat during WWII.

Without giving details, Jankowski, et al., observed that some of the participants in the tests were not volunteers, and some were repeatedly exposed. Veterans who participate in the study were 97.2% white, 82.9% married and were of the average age of 71.9 years, thus were asked to give retrospective accounts spanning 50 years.

The authors used a "structural equation model" using "path analysis" leading to a number of correlations between "contextual factors," such as the participants psychological reaction on initial exposure, number of exposures, whether or not the participant was adequately prepared, whether or not he volunteered, whether they were prohibited from disclosure, and their social support during the 50 year span. They found that "an initial adverse psychological reaction may be a key factor" in determining their risk for PTSD symptoms. "Less preparation, being ordered to participate in the tests, being prohibited from disclosing to others were associated directly with more posttraumatic symptoms. These event-related variables were only partially mediated through initial psychological reaction, suggesting that extent of exposure was related to PTSD symptoms only if there was a subjective response to intense distress or dissociation" (p. 309).

Jankowski, et al., reported a surprising finding that "higher levels of perceived social support were associated with greater PTSD symptoms" (p. 309). They speculate that "individuals who have more PTSD symptoms may have a greater need for social support and are those mobilizing and utilizing more social support relative to men to have no or few PTSD symptoms. As such, PTSD symptoms may be driving the increased report of social support instead of social support serving as a buffer against PTSD symptoms" (p. 309). The authors noted that this finding is contrary to research involving Vietnam War veterans, but more consistent with a broader literature that found that "people who experience greater amounts of stress engage in more coping strategies and report utilizing more social support that those who are less stressed…" (p. 309).

The authors were detailed in their cautions regarding the long term retrospective nature of their research. "Related to the retrospective design issues, there may have been a retrospective bias, causing overreporting of exposure, initial distress, and other risk factors among men with a higher level of PTSD symptoms, or under-reporting among men with fewer symptoms. Although it would have been preferable to have studied these men earlier in order to avoid the above-mentioned recall problems, such a study would not have been possible in light of the secrecy surrounding these tests" (p. 309).

Comment

The "secrecy" of the experiments conducted during WWII was maintained until 1990, reasonably far beyond the scientific need to protect the data. Jankowski, et al., (her co-authors consisting of international stars of trauma research: Paula Schnurr, Gary Adams, Bonnie Green, Julian Ford, and Matthew Friedman) compare the governments imposition of secrecy to that of child abusers (p. 304). It is particularly relevant since a number of the subjects were apparently ordered to participate. Jankowski, et al., observed that Vietnam War veterans who worked in mortuaries "were more likely to have PTSD if they were ordered to work as opposed to volunteering, and if they were not prepared for the work" (p. 304). The need for conducting the tests was most likely compelling, however, the long term secrecy has a hint of shame, guilt, and culpability. Not that the testing, per se, was wrong, but that the way it was conducted, ordering GIs to be experimental subjects, giving them inadequate preparation, and then swearing them to secrecy for decades following. These are the factors which the authors indicate as contributing to "the overconsolidation of trauma memories," and subsequently PTSD.

On a more positive note, there is a hint that our current wars being conducted in the Middle East may not lead to the social alienation that was the result for so many Vietnam War veterans, since the authors observed that the Vietnam War veterans social experiences may be been the exception rather than the rule. EE ##

VA, Army Criticized for Ducking Issue of Killing as Traumatic

An article by Dan Baum in the July *New Yorker* ("The Price of Valor," July 12 & 19, 2004, 44-52) attacks the federal Department of Veterans Affairs and the Army for avoiding the subject of killing. Mr. Baum writes, "Although both organizations have produced reams of studies on every other aspect of combat trauma—grief, survivor's guilt, fear, and so on—the aftereffects of taking an enemy's life are almost never studied" (p. 46). One army psychiatrist is quoted as referring to the subject of killing as "the dead elephant in the living room that nobody wants to talk about" (p. 47). The author quotes sources within the army combat training that suggest there is institutional resistance to the subject of killing because it would burden the soldiers. Mr Baum also quotes Dave Grossman, author of the influential *On Killing: The Psychological Cost of Learning to Kill in War and Society*, and a psychology professor at West Point. "A soldier traumatized by the killing he has done is a casualty, he said, but such casualties can be avoided if soldiers are taught, mentally, to confront the act of killing" (p. 48). Dr. Grossman states in his book, Mr. Baum noted, that if society trains its soldiers to kill, it has "an obligation to deal forthrightly, intelligently, and morally with the psychological event." (p. 48).

Mr. Baum, who is a *New Yorker* staff writer, notes the fact that WWII psychological casualties outnumbered the KIAs, and the army has since assigned a so-called combat stress team, consisting of six enlisted and three officers for every division. He noted also that the rate of suicide among soldiers in Iraq is nearly a third higher than the army's "historical average."

Mr. Baum cites the VA's 207 page "Iraq War Clinician Guide" which discusses civilian casualties, but nowhere indicates that killing enemy combatants might be traumatic. "No V.A. official was able to explain why, when other combat traumas have been so carefully studied and treatment models forumlated, the V.A. focusses so little attention on this one" (p. 51). Mr. Baum cites two possible motivators for VA avoidance, secondary trauma and the fact that many VA clinicians are themselves war veterans. He seems to imply that the VA is of the same thinking as the army, that is, we don't talk about traumatic work that has to be done, creating a collective silence among veterans and clinicians that avoids the subject. If wars are going to be considered traumatic on such a large scale, they would become impossible to justify, except under conditions of sheer survival.

Mr. Baum points out that the VA budget "has been strained by rising medical costs and by an aging veteran population; providing the same level of therapy that, say, the New York Police Department gives a cop involved in a shooting incident would be an unimaginable burden. Veterans since the American Revolution have complained that the government doesn't do enough for them. Given what combat does to soldiers, it's hard to imagine any amount of services being 'enough'" (p. 52).

Dan Baum wrote a follow-up article in the Aug 9 & 16, 2004 issue (pp 76-86) "Two Soldiers: The last journey home." This article respectfully follows two soldiers who go out on a patrol in Iraq and are killed in a roadside blast. It looks at the army's Graves Registration procedure and follows the family's funeral plans.

Comment

This reviewer's experience with combat veterans as clinicians is that they have more, not less, tolerance for addressing the reality of killing enemy combattants. The fact that combat veterans are generally avoidant of the subject is probably sound as an instinctive, evolutionary principal. It has been sugggested in research that focusing on traumatic material in an emotionally arousing way builds traumatic stress, kindles, if you will, creating greater likelihood of PTSD developing. Cognitive therapists have shown that they can reduce emotional association to memories, and therefore the likelihood of maintaining PTSD, by reviewing arousing memories in a carefully controlled environment. The number of everyday therapists who can do this may be small, and the risk of kindling PTSD is great in returning war veterans. The instinct is to clam up—if only other emotional connections didn't also shut off. Group psychotherapy among combat veterans probably has the best chance of talking about killing among an understanding audience, yet there are also those who find groups arousing rather than therapeutic.

There are essential services that clinicians can provide to combat veterans returning from the Middle East, such as knowledge of the dynamics of psychopathology—what is normal for a combat veteran. Clinicians can offer safety, confidentiality, and something hard to find among friends and family, objective perspective. They can suggest therapeutic choices, medicines that aid sleep, block nightmares, reduce obsessional thinking. Reliability, over time, means that the clinician is a professional who is going to be providing the same services for the predictable future. Traveling experts and media gurus are clever, but the veterans need to know who will be there for them when they need to check in. EE ##

Journal Editor Strikes a Personal Note on the History of PTSD

An editorial in the *American Journal of Psychiatry* [2004, 161 (8), 1321-1323] introduced 14 articles on or related to the subject of PTSD. Nancy C. Andersen, MD, PhD, wrote a lively and personalized view of the history of PTSD. She revealed that she was the author of the diagnostic text on the original DSM-III committee, and observed with some pleasure the expansion of scientific literature triggered by the creation of diagnosis 309.81. She bemoaned the fact that DSM-IV has widened the range of events that can be considered traumatic.

(An interesting historical sidelight, Dr. Andersen noted that it was the Veterans Administration after WWII that developed a diagnostic manual for psychiatry, stimulating the creation of DSM-1.)

Dr. Andersen wrote that she used her professional experience treating burn patients as her background for conceptualizing the topic of a traumatic stress disorder. She makes an interesting and provocative observation about the delayed nature of PTSD onset in Vietnam War veterans. She wrote that "a stress reaction in the midst of combat is not adaptive, and so the impact of their traumatic experiences is delayed" (p. 1322). What is provocative in her statement is the implication that there is an endogenous process, that is probably physiological, which protects one, at least temporarily, from PTSD.

Dr. Andersen concluded her editorial with an eloquent statement that bears quoting in full. "As the psychiatrist who was also midwife at the birth of PTSD, I have followed its growth and maturation with great interest. Others have parented it, and generally well. It is of particular interest in the 21st century, when the entire world is filled with the spectre of terrorism—a stressor of great magnitude that can strike any time and anywhere. This is also a time when we again will have many young soldiers returning from yet another war: the treacherous combat experience in Iraq and Afghanistan. Unfortunately, the present world situation is likely to give us many more oppotunities to study ASD [acute stress disorder] and PTSD. For this I have regrets, but I am pleased that I helped create a diagnostic category and conceptual framework for this important syndrome, so that its causes and consequences can be examined both clinically and scientifically" (p. 1323).

Comment

Dr. Andersen takes proper credit as "the midwife" of the PTSD diagnostic category that was immediately useful to clinicians and popular among researchers. However, she expressed regret that DSM-IV broadened Criterion A, allowing a range of more common mishaps that befall human beings, such as sudden death of loved one, or, as she cites, the victim of an auto accident. She observed a "clue" in referring to articles in the August issue of the Journal, one that places the PTSD frequency among survivors of a terrorist attack on the Paris Metro at 31% 2-1/2 years after, and another article that found the frequency of PTSD among plane crash disaster workers at 16.7%, suggesting that the epidemiological frequency of PTSD found among this range of events is a measure of the magnitude of the traumatic event.

EE ##

Researchers Follow French Victims of Terrorism

French researchers followed survivors of terrorist bombings of Metro stations, gathering data after 2-1/2 years. Pierre Verger, MD, and associates published their results in the August *American Journal of Psychiatry* [2004, 161(8), 1384-1389]. Authors report that "450 people applied for compensation from the French Terrorism Victim Guarantee Fund, a public guarantee fund to provide immediate financial aid and indemnification for health consequences and long term sequelae" (p. 1384). To qualify the subjects had to undergo a medical evaluation. Resarchers contacted the 228 subjects who were over age 18 and 196 agreed to participate in follow-up telephone interviews.

Verger, et. al., reported that 31.1% of the interview subjects were diagnosed with PTSD. "The prevalence of PTSD in those with severe injuries was 50% (...) and was lower in participants with moderate or mild injuries" (p. 1386). "Risk of PTSD was significantly higher for women; participants 35-54 years of age; those who were not working; those who lived alone; those whose marital situation had changed after the attack (divorced, widowed); those who had severe injuries, cosmetic impairment, or hearing problems; and those who reported a high perceived threat at the time of the attack or who had received treatment by a psychologist since the attack..." (p. 1386).

Authors noted that the rate of PTSD among moderately or mildly injured subjects was 27.2% and 26.0% respectively. Veger, et al., note that the age group that includes 35-54 year olds was also at greater risk for PTSD and speculate that this group was affected by "the substantial economic consequences" of the bombings.

The authors concluded their report by noting the significance of the large sample and the long time period of follow-up (2-1/2 years). "Our findings suggest that psychological care for some victims may have been inadequate in the 2-3 year period after the event and thus highlights the need for improved health services to address the intermediate and long-term physical, psychological, and social consequences of terrorism" (p. 1388).

The terrorist attacks were conducted by "Islamist fundamentalist networks" during the period of July, 1995, to December, 1996. The bombings struck six metro stations in Paris and one in the Lyon region. Verger, et. al, note the cross-sectional nature of the victims' backgrounds. They also note that relatively few (11) of those interviewed reported that they had previous psychiatric problems.

Comment

Researchers comment on the risk of PTSD from a terrorist bombing and the need for early intervention. Other articles in this *RAQ* have drawn attention to the early intervention efforts of returning Iraqi and Afghanistan combat veterans. Early intervention raises the risk of kindling PTSD if it is done in a way that raises fears. Army veterans who reported PTSD were the least likely to seek help. EE ##

Movie Review:

The Manchurian Candidate: Then and Now.

Reviewed by Emmett Early

The movie theater where I saw the new version of *The Manchuran Candidate* is a rather unpleasant modern cave of high tech. The latest *Manchurian* has the same unpleasant, alienating emphasis on glitz and technology. The first *Manchurian Candidate* was released in 1962, and was considered a major film release with the Queen of Diamonds as its advertising logo. It concerned a group of Korean War veterans who had been captured by Russian paratroopers and then released. All the captives ageed that one man stood out as a hero and he, Raymond Shaw (Lawrence Harvey), received the Congressional Medal of Honor. Another common thread among the survivors was that they had similar nightmares and mimicked the same rote language when talking about their hero.

The 2004 version was directed by Jonathan Demme and the Manchurian connection is to an international corporation, Manchurian Global. The war in question is ostensively the first Gulf War. In the 1962 version, Frank Sinatra was the leading man, playing Major Marco, who persistently investigates the strange events. It was the first movie to suggest the concept of the war veteran as a walking time bomb. Then it was evil Asian Communists who had hypnotized the squad of GIs and set up a "sleeper" who would kill on cue. The shift of the identity of evil certainly reflects the times—from Asian Communism to international corporate conspiracy.

Queen of Diamonds

The Queen of Diamonds in the 1962 version refers to the hypnotic que used to trigger Raymond Shaw to kill the presidential victor, allowing the vice president (a pawn for the real conspirator) to take over. The agent of the Communist conspiracy was Shaw's mother, the archetypal ice queen mother, Angela Lansbury. Meryl Streep takes on the role with malicious delight in the Demme version, providing in total the only comic relief in the movie. She wears an array of diamonds, chews ice with relish, wears a black gown like a witch, and reveals an incestuous love for her son.

The main protagonist in the updated Frank Sinatra role is Denzel Washington, who plays Major Marco. He is still in uniform and is drawn into questioning what happened by the suffering and death of another veteran of the squad. The scenes of suffering and the struggle with paranoid conspiracy harken to other war veteran thrillers using intrusive memories, *Conspiracy Theory* and *Jacob's Ladder.*

There is a spooky and probably intentional allusion to the current presidential campaign. Manchurian Global is a mega corporation that has cornered the market on government contracts, is creating its own private army to contract with whomever, and is protected by patronage of leading politicians. The controversy over what really happened in the fire fights of combat, who was the hero and what did he really do, directly addresses John Kerry's campaign, even to the use of his war record as a credential for political office: "We faced the enemy on the battlefield." Shaw (played by Liev Schreiber in the 2004 version) is described in the campaign ads as a millionaire Harvard graduate who volunteered for military duty. He even at one point uses the phrase "compassionate vigilance" as a campaign slogan. Raymond Shaw as vice presidential candidate in the 2004 version has a spooky resemblance to John Edwards as he is hyped. (He also has an uncanny resemblance to the actor in the original part, Lawrence Harvey.)

As Denzel Washington's Major Marco tries to ferrit out the truth, the Army brass allude to Gulf War Syndrome and PTSD and order him to "resume your medication." Instead of the wiley Asian use of hypnosis in the 1962 version, the method of controlling and awakening the veteran is an insideous implant: a pill-like little electronic machine that mixes memories with implanted facts. At one point in the 2004 version, Major Marco has ECT done, ironically, to clear out all the memory confusion. The implant seems to work the same as the hypnotic suggestion, as one veteran suggests, "Somebody got into our heads."

Rosie is Riveting

Jon Voight plays Senator Jordon, the liberal politician who is killed on command. Kim Elise plays Rosie, major Marco's love interest, a role given a huge elaboration in the 2004 version. In 1962, she was played by Janet Leigh, in a delightful but brief performance. Rosie in the 2004 version is an FBI agent who comes to believe in Marco.

The tyranny of technology and its intrusion into our every day life is hammered home in the updated version of *Manchurian Candidate.* Mrs. Shaw communicates the triggering cue to her son via a cell phone. The evil corporate doctor is a genome researcher. Technology drives the political campaign and displays the action with a myriad of glitzy screens. The politicians themselves appear as pawns to the technology, hitting their marks, like ballplayers waiting for the commercial to end so they can resume play. In the face of this tyranny, the war veterans appear to be under seige and struggle to communicate with each other. One asks Marco, "are we friends?" "We're connected," replies the Major.

There were a number of plot devices in the 2004 version that left me confused. The glitter technology not only is the message, but also the messenger, and I left the theater glad to hear a bird song. The two versions share the basic message, that combat is confusing, its effects linger in a potentially destablizing way, and simply resuming one's medicine does not tuck away the memories. ##

Dave Holden, Vet Center Veteran, Retires

By Steve Akers

I attended Dave Holden's retirement party in Tacoma on 8/29/04. Dave retired after 29 years of federal service. He served in the US Army as a door gunner in Vietnam. He working for the Idaho State Department of Health when I met him in 1978, while I was on internship in the state hospital. While working with Dave, I always felt comfortable. A few months after I finished the internship, I received a call from Dave and he told me he needed to talk. We talked about Vietnam and how he was having problems with the war. I did not understand, but I also felt a need to talk. We decided that there may be other Vietnam War veterans who felt the way we did. We had a local newspaper give us free space and the college gave us a room to use. That night 35 Vietnam veterans came, along with an undercover cop (also a Vietnam War veteran), and John McCay, the Team Leader of the Vet Center in Boise, Idaho, which had opened in 1979. The VA wanted to open the Spokane Vet Center and in January, 1980, Dave and I were hired.

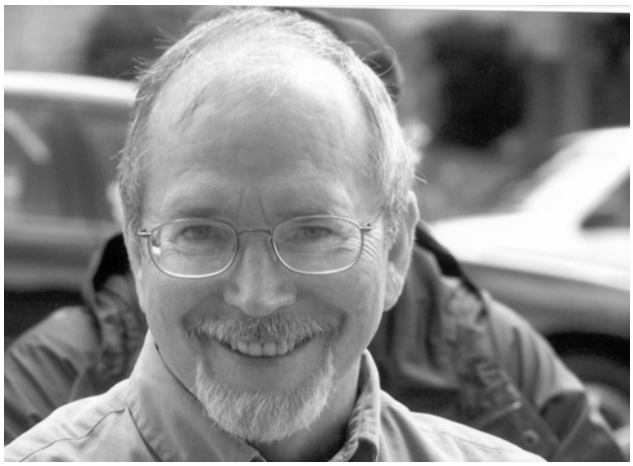
I really loved working at the Vet Center with Dave. I left after a veteran nearly killed me in a suicide attempt. Dave tried to talk me into staying, but I could no longer walk into the building without severe anxiety. Dave fought the VA and demanded they give me an award and $500. That is the kind of guy Dave is. He will fight for you and will not stop until you get the help you need. He was the same with his clients. At his retirement party the members of the five different groups he ran at the Tacoma Vet Center very clearly expressed how he helped them.

I have never seen veterans express their feelings as clearly as they did at the party for Dave. They all, to the person, shared the love and thanks for his 25 years of service to veterans. Dave will be greatly missed at the Vet Center. He has done more than his share in helping veterans deal with PTSD.

Dave is a great therapist and I have tried to model myself after him, although he is a hard act to follow. I am very happy for Dave and hopefully we will be able to spend a little more time together now that he has more time. Knowing Dave, his heart is too big to stop helping, so I can imagine him finding another way to give his love to people.

My best wishes and prayers go to a great man, a friend, and a model therapist. ##

Steve Akers, MSW, is a WDVA Contractor and director of Akers Counseling in Everett.



Above is Dave Holden, MSW, at his Tacoma Vet Center retirement party celebrating his 29 years of federal service. Dave began as a PTSD counselor at the Spokane Vet Center in 1980.

Below is Steve Tice, also a retired Vietnam War veteran, seen here checking Dave's bag for any government pens or paper clips he might be taking with him as he leaves the Vet Center for the last time.

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The Director of the King County Veterans Program is Joel Estey. Frank Kokorowski, MSW, is a King County employee and the Program's full-time clinician.

The King County Veterans Program, which also provides vocational counseling and emergency assistance, is located at 123 Third Ave. South, Seattle, Washington, Telephone 206 296 7656. The King County program works in cooperation with WDVA to provide counseling and evaluations to veterans incarcerated in King County.

To be considered for service by a WDVA or King County contractor, a veteran or veteran's family member must present a copy of the veteran's discharge form, DD-214, that will be kept in the contractor's file as part of the case documentation. Occasionally, other documentation may be used prove the veteran's military service. You are encouraged to call Tom for additional information.

It is always preferred that the referring person telephone ahead to discuss the client's appropriateness and the availability of time on the counselor's calendar. Contractors are all on a strict and tight monthly budget, however, contractors in all areas of the state are willing to discuss treatment planning .

Some of the program contractors conduct both group and individual/family counseling. ##

The Repetition & Avoidance Quarterly **is published each season of the year by the Washington Veterans PTSD Program, of the Washington Department of Veterans Affairs. The PTSD program's director is Tom Schumacher. The editor of the *RAQ* is Emmett Early. It is intended as a contractors' newsletter for the communication of information relevant to the treatment of PTSD in war veterans and their families. Your written or graphic contribution to the PTSD Program newsletter is welcomed if it is signed, civilized, and related to our favorite topics of PTSD and war veterans. Contributions may be sent by mail to the Washington Department of Veterans Affairs (Attn: Tom Schumacher), PO Box 41150, Olympia, WA 98504, or by Email directly to <emmett@dva.wa.gov>. Readers are also invited to send in topical research or theoretical articles for the editorial staff to review. Comments on items reported in the *RAQ* are also encouraged and will likely be published if they are signed. To be included in our mailing list, contact WDVA, Tom Schumacher, or Emmett Early. The *RAQ* can also be read online by going to www.dva.wa.gov. Once in the WDVA Website, click on PTSD, and once on the PTSD page, scroll to where you find access to the *RAQ*. The newsletter logo is a computerized drawing of a photograph of a discarded sign, circa 1980, found in a dump outside the La Push Ocean Park Resort. ##**